

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 12078
County A-A-

Village or City Annapolis (No. 12 Jefferson Place) St.; Ward

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Oscar Blackson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH unknown, 1 ____
(Month) (Day) (Year)

7 AGE about 70 unknown about If LESS than 1 day, ____ hrs. ____ yrs. ____ mos. ____ ds. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah Blackson

(Address) 12 Jefferson Place

15 Filed Aug 9, 1915 Jms Welch
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 8, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1915, to Aug 7, 1915.
that I last saw him alive on Aug. 7, 1915

and that death occurred on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:

Acute valvular heart disease
(Duration) ____ yrs. ____ mos. 30 ds.

Contributory Exhaustion, debility
Secondary (Duration) ____ yrs. ____ mos. 12 ds.

(Signed) Harold Z. Woodward, M. D.
Aug. 9, 1915 (Address) 80 Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL St. Calvary Cemt. DATE OF BURIAL 8.10., 1915.

20 UNDERTAKER E. B. Parker & Son ADDRESS 92 West St
Norwood

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 7 1915

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH <u>12079</u>		STATE OF MARYLAND	
County <u>Anne Arundel</u>		CERTIFICATE OF DEATH	
Village or City <u>Bladen</u> (No. <u>70</u>)		Registration Dist. No. <u>20</u>	
2 FULL NAME <u>Rachel Brown Blake</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Negro</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	
6 DATE OF BIRTH <u>Aug. 28th, 1876</u> (Month) (Day) (Year)			
7 AGE <u>39</u> yrs. <u>0</u> mos. <u>4</u> ds.		If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Chas Brown</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Not known</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Chas Blake</u> (Address) <u>Bladen, Md</u>			
15 Filed <u>191</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Aug 30th, 1915</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>May 1st, 1915</u> to <u>Aug 30th, 1915</u> , that I last saw her alive on <u>Aug 26th, 1915</u> , and that death occurred on the date stated above, at <u>12 noon</u> m.			
The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u> <u>(only knew patient 4 months)</u> (Duration) = <u>9</u> yrs. <u>9</u> mos. <u>6</u> ds.			
Contributory <u>Weariness & Poisoning</u> Secondary (Duration) = <u>9</u> yrs. <u>9</u> mos. <u>6</u> ds.			
(Signed) <u>Quentin Hayes</u> , M. D. <u>Aug 31st, 1915</u> (Address) <u>Darwinville Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>9</u> yrs. <u>9</u> mos. <u>6</u> ds. to the State <u>9</u> yrs. <u>9</u> mos. <u>6</u> ds. Where was disease contracted, if not at place of death? Former or usual residence.			
19 PLACE OF BURIAL OR REMOVAL <u>Chew's Chapel Cemetery, A. A. Rd.</u>		DATE OF BURIAL <u>Sept 1st, 1915</u>	
20 UNDERTAKER <u>Morris Talbot</u>		ADDRESS <u>Darwinville Md</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

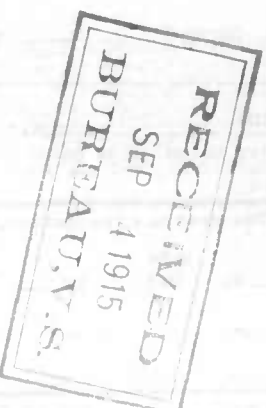
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc., State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolvier wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Cauc

5 SINGLE, MARRIED, WIDDED OR DIVORCED
(Write the word)

Infant

6 DATE OF BIRTH

Aug 20, 1915
(Month) (Day) (Year)

7 AGE

7 yrs. 7 mos. 7 ds.
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Mr. Blair

11 BIRTHPLACE OF FATHER

Virginia

12 MAIDEN NAME OF MOTHER

Gertrude Conner

13 BIRTHPLACE OF MOTHER

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louise Conner

(Address)

Brooklyn A.D. Md.

15

Filed

Aug 28, 1915

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 27, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

New York City, 1915 to Aug 27, 1915

that I last saw him alive on Aug 27, 1915

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH * was as follows:

Convulsions

(Duration) yrs. mos. ds.

Contributory
Secondary

(Signed) Thomas H. Grayhan, M.D.

Aug 27, 1915 (Address) Brooklyn A.D. Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Funeral Home

DATE OF BURIAL

Aug 28, 1915

20 UNDERTAKER

Henry J. Juggs

ADDRESS

Brooklyn A.D. Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masks*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverer wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

SEP 7 1915

BUREAU, U. S. S.

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1 PLACE OF DEATH

13080

County

A-A-

104

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Germantown (No. 107, Billhouse Row

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Priscilla Bowie

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE,

MARRIED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

June 10, 1915
(Month) (Day) (Year)

7 AGE

3 yrs. 20 mos. 20 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

A-A-Co-Md.

10 NAME OF FATHER

Frank Bowie

11 BIRTHPLACE OF FATHER
(State or country)

Davidsonville Ind.

12 MAIDEN NAME OF MOTHER

Bertha Cacy

13 BIRTHPLACE OF MOTHER
(State or country)

Davidsonville Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bertha C. Bowie

(Address)

107, Billhouse Row

15

Filed

Sept 1, 1915 Jmg Wtch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

August 30, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

August 29, 1915, to August 30, 1915,

that I last saw her alive on August 30, 1915,

and that death occurred on the date stated above, at 9⁰⁰ m.

The CAUSE OF DEATH * was as follows:

Gastro Enteritis

(Duration) yrs. 7 mos. 7 ds.

Contributory
Secondary

(Duration) yrs. 7 mos. 7 ds.

(Signed)

Aubrey Garcia, M. D.

9-1

1915 (Address) Annapolis Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asbury Cemt.

9. 2, 1915

20 UNDERTAKER

ADDRESS

E.H. Barker & Son

92 West St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

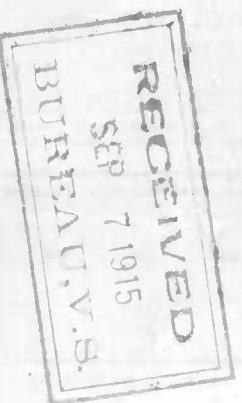
[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

St.;

Ward)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDDED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory
Secondary

(Signed)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

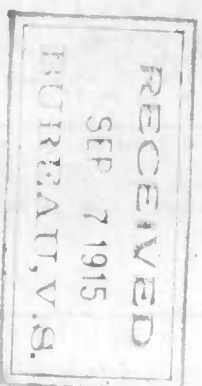
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverer wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

13082

County

A. C. Co.

Village or City

Castport

(No.

104

Registration Dist. No.

21

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John H. H. Brown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Apr. 19, 1915
(Month) (Day) (Year)

7 AGE

yrs. 4 mos. 3 ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE (State or country)

Castport Md

10 NAME OF FATHER

James H. Brown

11 BIRTHPLACE OF FATHER (State or country)

Annapolis Md

12 MAIDEN NAME OF MOTHER

Annie C. Mullen

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James H. Brown

(Address)

2nd & Green Aves.

15

Filed

Aug 23, 1915 - JMS Welch

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 22nd, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1915, to Aug. 22nd, 1915,that I last saw him alive on Aug 22nd, 1915

and that death occurred on the date stated above, at 8.30 A.M.

The CAUSE OF DEATH* was as follows:

Enterocolitis,

(Duration) yrs. 1 mos. 20 ds.

Contributory (Secondary)

Convulsions,

(Duration) yrs. mos. ds.

(Signed)

Louis S. Henkel M. D.

Aug 23, 1915 (Address) Annapolis, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Annes Cem Aug 23, 1915

20 UNDERTAKER

ADDRESS

Woolley & Son 22 Murray Ave.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

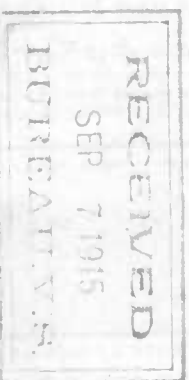
[Approved by L. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			13083		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Anne Arundel</u>					Registration Dist. No. <u>22</u>	
Village or City <u>Gambrell</u> (No. <u>175</u>)			St. <u></u> Ward <u></u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Sarah J. Brown</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)				
6 DATE OF BIRTH <u>unknown unknown 1864</u> (Month) (Day) (Year)						
7 AGE <u>57</u> yrs. — mos. — ds. If LESS than 1 day, hrs. OR min. ?						
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House-wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>House-work</u>						
9 BIRTHPLACE (State or country) <u>Maryland</u>						
PARENTS						
10 NAME OF FATHER <u>Isaac Brown</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>						
12 MAIDEN NAME OF MOTHER <u>Unknown</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>London Brown</u> (Address) <u>Gambrells Md.</u>						
15 Filed <u>Aug 16</u> , 1915 <u>Holiday A. Star</u> REGISTRAR						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Aug 14</u> , 1915 (Month) (Day) (Year)						
17 I HEREBY CERTIFY, that I attended deceased from <u>191</u> , to <u>191</u> , that I last saw him alive on <u>191</u> , and that death occurred on the date stated above, at <u>m.</u>						
The CAUSE OF DEATH * was as follows: <u>Shock caused by fall from moving car on W. B. & A. Electric R. R. accident</u> (Duration) <u>10 minutes</u> yrs. — mos. — ds.						
Contributory Secondary <u>1</u> (Duration) <u>1</u> yrs. — mos. — ds.						
(Signed) <u>Byron Phelps</u> M. D. <u>August 16 1915</u> (Address)						
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.						
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs. — mos. — ds. In the State, <u>1</u> yrs. — mos. — ds. Where was disease contracted, If not at place at death? Former or usual residence <u></u>						
19 PLACE OF BURIAL OR REMOVAL <u>Gal. Labor cemetery A. A. Co.</u> DATE OF BURIAL <u>August 16, 1915</u>						
20 UNDERTAKER <u>R. P. Williams</u> ADDRESS <u>Waterbury Ind.</u>						

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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SEP 3 1915
BUREAU, V. S.

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1 PLACE OF DEATH County <u>aa</u>		13084		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Bay Ridge</u>		(No. _____)		Registration Dist. No. <u>21</u>	
2 FULL NAME <u>George Richard Buffham</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>July 20, 1896</u> (Month) (Day) (Year)		7 AGE <u>69</u> yrs. — mos. <u>18</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		<u>Retired Photographer</u>			
9 BIRTHPLACE (State or country)		<u>London Eng</u>			
PARENTS	10 NAME OF FATHER	<u>Geo. R. Buffham</u>			
	11 BIRTHPLACE OF FATHER (State or country)	<u>London Eng</u>			
	12 MAIDEN NAME OF MOTHER	<u>May Johnson</u>			
	13 BIRTHPLACE OF MOTHER (State or country)	<u>London Eng</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Geo R. Buffham</u> <u>Bay Ridge</u> (Address) <u>aa Co Md</u>					
15 Filed <u>Aug 8, 1915</u>		16 REGISTRAR <u>Amg Metch</u>			
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>August 7, 1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>July 23, 1915</u> , to <u>Aug 7, 1915</u> , that I last saw him alive on <u>Aug 7, 1915</u> , and that death occurred on the date stated above, at <u>11 P. M.</u>					
The CAUSE OF DEATH * was as follows: <u>Cerebral Hemorrhage</u>					
Contributory <u>Arteriosclerosis</u> Secondary <u>Tuber Dorsalis Unknown</u> (Duration) ____ yrs. ____ mos. <u>15</u> ds.					
(Signed) <u>Walter H. Hoffman</u> , M. D. <u>Aug 8, 1915</u> (Address) <u>Annapolis Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not of place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Sound Beach Ct.</u>				DATE OF BURIAL <u>Aug 8, 1915</u>	
20 UNOBTAINER <u>James S. Taylor</u>				ADDRESS <u>Annapolis</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

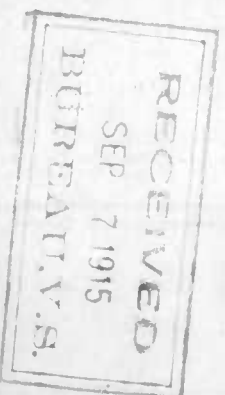
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Trucey*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Anne Arundel

Village or City

Shady Side

(No.)

St.;

Ward)

2 FULL NAME

Beatrice Butler

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

black

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Infant

6 DATE OF BIRTH

Oct, 7, 1914

7 AGE

10 yrs. 20 mos. 20 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Infant

9 BIRTHPLACE

(State or country)

Baltimore Md.

10 NAME OF FATHER

Charles Butler

11 BIRTHPLACE OF FATHER

Maryland

12 MAIDEN NAME OF MOTHER

Daisy Putman

13 BIRTHPLACE OF MOTHER

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daisy Butler

(Address)

Baltimore

15

Filed Aug. 30, 1915

Geo. T. Smith M.D.
Sgt. Gen. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug. 29th, 1915

17 I HEREBY CERTIFY, That I attended deceased from

Aug 26, 1915, to Aug 28, 1915,

that I last saw her alive on Aug 27, 1915,

and that death occurred on the date stated above, at 30 m.

The CAUSE OF DEATH * was as follows:

Broncho Pneumonia

Contributory

Dysentery

(Signed)

Jesse C. Howards M. D.
Aug 29, 1915 (Address) Shady Side Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St Peter's Cemetery, Balto Md

DATE OF BURIAL

Aug 31, 1915

20 UNDERTAKER

Hardesty & Hunt

ADDRESS

Galloways Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

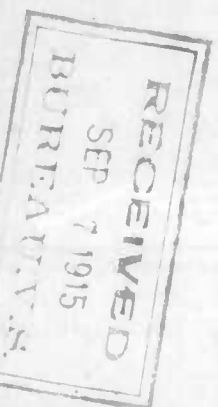
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma, Scirrhus*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meesles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *River boat wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County AlleghenyVillage or City Millersville (No. 76) St. Ward

2 FULL NAME

Clara CecilSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH unknown
(Month) (Day) (Year)

7 AGE 48 yrs. mos. ds. 1 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION House work
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER Johannes Cecil11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Susan Dodson13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Intendant) J. S. Larimore
(Address) Millersville Ind.

15 Filed 8/5 1915 S. D. Jope
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 4, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1915 to Aug 4, 1915,
that I last saw him alive on Aug 4, 1915.

and that death occurred on the date stated above, at 12:10 P. M.
The CAUSE OF DEATH* was as follows:

Chronic Pulmonary
Tuberculosis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. B. J. Smith, M. D.
Aug 4, 1915 (Address) Millersville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baldwin Mem. M.E. Church DATE OF BURIAL 8/6, 1915

20 UNDERTAKER R. T. Williams ADDRESS Law Wabersburg
Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

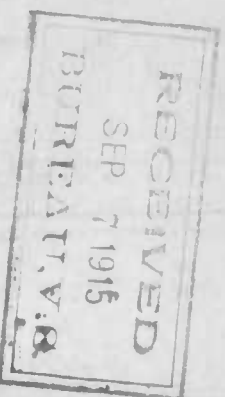
Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Typhoid," "Marasmus," "Old Age," "Shock," "Trachia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

13087

County

a-a-

Village or City

Annapolis (No. —, Clay

2 FULL NAME

Harry Cook.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

St. Ext. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colord 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH

Jan - 7, 1915 (Month) (Day) (Year)

7 AGE

— yrs. 28 mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Annapolis Md.

PARENTS

10 NAME OF FATHER

Thomas Cook

11 BIRTHPLACE OF FATHER (State or country)

Annapolis Md.

12 MAIDEN NAME OF MOTHER

Alice Smith

13 BIRTHPLACE OF MOTHER (State or country)

Annapolis Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Cook

(Address)

Clay Street Ext.

15

Filed

Aug 6, 1915 Mrs Melch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 5th, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 31st, 1915 to August 5th, 1915, that I last saw him alive on August 5th, 1915, and that death occurred on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. ds.

Contributory Secondary

Asthma (Duration) yrs. mos. ds.

(Signed)

Eugene Bidont, M. D.

(Address)

Annapolis Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Brewerhill Cmt

DATE OF BURIAL

8-17, 1915

20 UNDERTAKER

E. H. Barker & Son

ADDRESS

92 West St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Bidont

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or even up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

SEP 7 1915

BIRMINGHAM, ALA.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

13088

County

Anne Arundel

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Annapolis

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Addie Julia T. Brown Cox

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Don't Know

(Month)

(Day)

(Year)

7 AGE

25

yrs.

mos.

ds.

If LESS than
1 day... hrs.
OR... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Domestic

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Washington D.C.

10 NAME OF FATHER

Don't Know

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

Don't Know

12 MAIDEN NAME OF MOTHER

Don't Know

13 BIRTHPLACE OF MOTHER

(State or country)

Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. P. Adams

(Address)

26 Calvert St.

15

Filed Aug 12, 1915

Mrs. Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 11

(Month)

(Day)

(Year)

Aug 11, 1915

17 I HEREBY CERTIFY, That I attended deceased from

Aug 10, 1915, to Aug 10, 1915,

that I last saw her alive on Aug 10, 1915,

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH * was as follows:

Pulmonary tuberculosis

No history of tuberculosis

(Duration)

yrs.

mos.

ds.

Contributory
Secondary

Overexertion

(Duration)

yrs.

mos.

ds.

(Signed)

R. B. Millins

M. O.

Aug 11, 1915 (Address) 25 Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State,

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D.C.

Aug 12, 1915

20 UNDERTAKER

ADDRESS

L. A. Adams

Annapolis

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

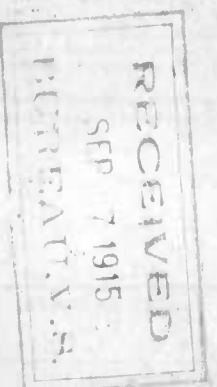
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolving wound of head—homicide*; *Poisoned by catholic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

a-a-

Village or City

Annapolis

(No.

Obryan, Alley

Registration Dist. No.

21

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

about unknown, 1 (Month) (Day) (Year)

7 AGE

about 62 yrs. — mos. — ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Sailor

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Annapolis Md.

10 NAME OF FATHER

James Davis

11 BIRTHPLACE OF FATHER

Annapolis Md.

12 MAIDEN NAME OF MOTHER

Margaret Davis

13 BIRTHPLACE OF MOTHER

Annapolis Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lily Davis Parker

(Address)

South St.

15

Filed Aug 10, 1915 JMS:mlch

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 8, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw h. alive on , 191,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Concussion of the brain caused by falling down steps (accidental)

(Duration) yrs. mos. ds.

Contributory

Secondary

(Signed)

William F. Minnick, M.D.

Aug. 10, 1915

(Address)

Annapolis Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State, yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brewershill Cent.

8.10.1915

20 UNDERTAKER

ADDRESS

E.H.B. Parker & Son

92 West St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

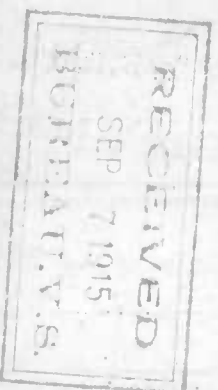
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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PLACE OF DEATH

13090

County

Anne Arundel

Village or City

Watertown

(No.

FULL NAME

Summerfield Diggs

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No.

211

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

Black

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

DATE OF BIRTH

July 31, 1925

AGE

6 yrs. 6 mos. 6 ds. It LESS than 1 day, hrs. OR min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country)

Maryland

PARENTS
10 NAME OF FATHER

John Diggs

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Kathrine Brewer

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma Diggs

(Address)

Watertown, Md.

15

Filed

8/6, 1915

J. D. Joyce

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 6, 1915

17

I HEREBY CERTIFY, That I attended deceased from

1915, to 1915,

that I last saw him alive on 1915

and that death occurred on the date stated above, at m,

The CAUSE OF DEATH* was as follows:

Bronchitis

No physician in attendance

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. D. Joyce, Justice of the Peace, acting as Coroner for State of Maryland

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

John Wesley Cemetery

8/7, 1915

20 UNDERTAKER

ADDRESS

P. P. Williams, Son, Watertown, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED

SEP 7 1915

BUREAU, V. H.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Anne Arundel</u>		13091		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>McKendree</u> (No. _____)		St.; _____ Ward)		Registration Dist. No. <u>26</u>	
2 FULL NAME <u>Mary Dorsey</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>Dec. 24, 1863</u> (Month) (Day) (Year)					
7 AGE <u>51</u> yrs. <u>8</u> mos. <u>4</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Md.</u>					
PARENTS	10 NAME OF FATHER <u>Easton</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Walter Dorsey</u> (Address) <u>McKendree</u>					
15 FILED <u>Aug. 28, 1915</u> <u>A. A. Perrie</u> <u>Local</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Aug. 28, 1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug. 24, 1915</u> to <u>Aug. 28, 1915</u> , that I last saw her alive on <u>Aug. 27, 1915</u> , and that death occurred on the date stated above, at <u>4 A.</u> m.					
The CAUSE OF DEATH* was as follows: <u>Typhoid fever</u>					
(Duration) _____ yrs. _____ mos. <u>8</u> ds.					
Contributory Secondary _____					
(Signed) <u>A. A. Perrie</u> , M. D. <u>Aug. 28, 1915</u> (Address) <u>McKendree Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Friendship, Md.</u> DATE OF BURIAL <u>Aug. 29, 1915</u>					
20 UNDERTAKER <u>Ralph J. Wood</u> ADDRESS <u>Friendship, Md.</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

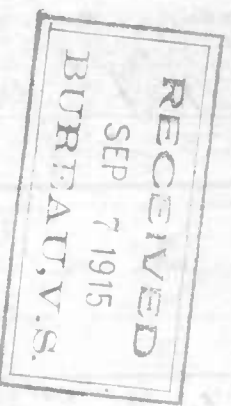
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1 PLACE OF DEATH

County A A Co

13092

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Magothy (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Thomas E Duwall

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, married
WIDOWED, OR DIVORCED
(Write the word)

6 DATE OF BIRTH May 2, 1840
(Month) (Day) (Year)

7 AGE 75 yrs. 3 mos. 6 ds. If LESS than
1 day. _____ hrs.
OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER L. Duwall

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Whitehead

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard B Duwall (Son)(Address) Tolley A A Co Md

15 Filed Aug 10, 1915 J S Beclungler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 9, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1915, to August 7, 1915,
that I last saw him alive on Aug 7, 1915,
and that death occurred on the date stated above, at 3 P m.

The CAUSE OF DEATH * was as follows:

Chronic Nephritis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) James S Beclungler, M. D.
Aug 10, 1915 (Address) Ebony Mg

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Magothy Cemetery DATE OF BURIAL Aug 11, 1915

20 UNDERTAKER Armstrong & Co ADDRESS 715 Light St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranquity," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
SEP 7 1915
BUREAU U. S.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

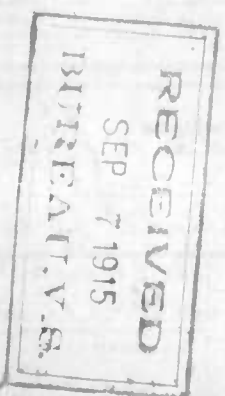
[Approved by U. S. Census and American Public Health Association.]

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

13094

County

a-a-

Village or City

Annapolis

(No.

103

Clay

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Elizabeth O'Neil Embury

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE,

MARRIED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

July

12

1914

(Month)

(Day)

(Year)

7 AGE

1

yrs.

1

mos.

18

ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Annapolis Ind.

10 NAME OF FATHER

Richard Embury

11 BIRTHPLACE OF FATHER

Philadelphia Pa.

12 MAIDEN NAME OF MOTHER

Eldadys Makall

13 BIRTHPLACE OF MOTHER

Annapolis Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Richard Embury

(Address)

103 Clay Street

15

Filed

Aug 27, 1915

JMS Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 26th, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY That I attended deceased from

August 15th, 1915, to August 26th, 1915,that I last saw ~~her~~ alive on August 25th, 1915

and that death occurred on the date stated above, at 11 A m.

The CAUSE OF DEATH * was as follows:

Gastro-enteritis
Several days

Contributory

Secondary

Gradual

(Signed) John Bidout, M. D.

(Address) Annapolis

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brewerhill Cmt.

8-27-15

20 UNDERTAKER

ADDRESS

E.H.B. Parker & Son.

92 West- St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Bidout

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Auto-motive factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Clerk," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household-only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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RECEIVED
SEP 7 1915
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V. S. No. 1.

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1 PLACE OF DEATH

13095

County a. q.Village or City Solley P. O. (No. 5)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 24

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Fields (Still birth)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Aug 7, 1915
(Month) (Day) (Year)

7 AGE Still birth If LESS than 1 day, ____ hrs. OR ____ min. ?
yrs. ____ mos. ____ ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Solley Md

PARENTS
10 NAME OF FATHER Richard Fields
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Marcelina Fields
13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Fields(Address) Solley, Md.

15 Filed Aug 2, 1915 J. B. Foster REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 7, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1915, to Aug 7, 1915,

that I last saw him alive on _____, 191____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Still birth

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. L. ... M. O. Aug 7, 1915 (Address) ...

*State the DISEASE CAUSING DEATH, of, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marley Neck Aug 7, 1915

20 UNDERTAKER ADDRESS

Richard Fields Solley

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

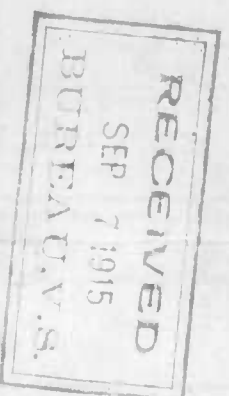
[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Muscles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachina," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or marriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state means of injury and qualify as *accidental*, *succidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rendered wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

13096

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

AA

Registered No.

21

Village or City

St. Margaret's

(No.

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Elizabeth Carey Hewitwood

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Unknown, 1866
(Month) (Day) (Year)

7 AGE

49

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR mo. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Annapolis Md.

PARENTS

10 NAME OF FATHER

Alexander Carey

11 BIRTHPLACE OF FATHER (State or country)

Georgia

12 MAIDEN NAME OF MOTHER

Ellen Adams

13 BIRTHPLACE OF MOTHER (State or country)

A.A. Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles X. Hewitwood

(Address)

Annapolis Md. R 75-1

15

Filed

Sept 1, 1915

HMS Melch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 31, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 10, 1915, to Aug 31, 1915

that I last saw her alive on Aug 31, 1915

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Abdominal

(Duration) 8 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. B. Ridout, M. D.
Sept 1, 1915 (Address) Annapolis Md. R 75-1

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Broadneck A.C.M. Sept 2, 1915

20 UNDERTAKER

ADDRESS

Jas. T. Taylor Sons Annapolis Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
SEP 7 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH A. A. 13097

County A. A.

Village or City Annapolis (No. Pri Geo.) St. 1 Ward

Registration Dist. No. 21

2 FULL NAME Bernardine Frank

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH Feb 13, 1827
(Month) (Day) (Year)

7 AGE 88 yrs. 6 mos. 16 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MARIEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Aug. 30, 1915Am S Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8 29, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1914, to Aug 29, 1915, that I last saw her alive on Aug 29, 1915, and that death occurred on the date stated above, at 89 m.

The CAUSE OF DEATH * was as follows:
Apoplexy

(Duration) yrs. mos. 2 ds.

Contributory Senility
Secondary

(Signed) J. J. Murphy, M. D.

(Address) Annapolis Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Mary's Cent DATE OF BURIAL Sept 1, 1915

20 UNDERTAKER James S. Taylor ADDRESS Annapolis Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

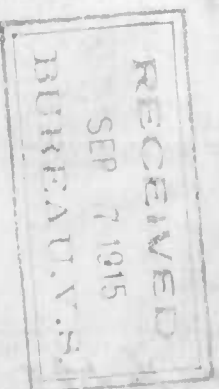
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Trocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH A. A. Co. 13098 (69)
 County New Land
 Village or City New Land (No. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Sarah Jane N. Gauthier Registration Dist. No. 22

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH Mar 29 1910
 (Month) (Day) (Year)

7 AGE 45 yrs. 6 mos. 7 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) Housework

9 BIRTHPLACE (State or country) B. Geo. Co. Md.

PARENTS
 10 NAME OF FATHER Wm. Henry Franklin
 11 BIRTHPLACE OF FATHER (State or country) B. Geo. Co. Md.
 12 MAIDEN NAME OF MOTHER Mary E. Roberts
 13 BIRTHPLACE OF MOTHER (State or country) B. Geo. Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Ruth Carter

(Address) Washington D.C.

15 Filed September 14, 1915 L. H. 21 1st Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 31st, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30th, 1915, to Aug 30th, 1915, that I last saw her alive on Aug 30, 1915, and that death occurred on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Epilepsy State
 (Duration) 2 yrs. 2 mos. 2 ds.

Contributory Epilepsy
 Secondary (Duration) 2 yrs. 2 mos. 2 ds.

(Signed) J. H. Bennett, M. D.
Aug 31st, 1915 (Address) Laurel Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death yrs. mos. ds. In the State, yrs. mos. ds.
 Where was disease contracted, if not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Marshall DATE OF BURIAL Sept 2nd, 1915

20 UNDERTAKER Geo. E. French ADDRESS Laurel Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

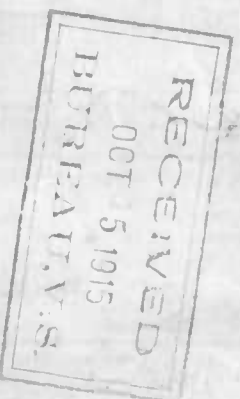
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

13099

County

a. a

Village or City

Jessup

(No.

St.:

Ward)

Registration Dist. No.

12

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Benjamin Galloway

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

widower

6 DATE OF BIRTH

June

(Month)

(Day)

1874 (Year)

7 AGE

41

yrs.

2

mos.

ds.

If LESS than 1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Iron moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Galloway

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

Not known

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER

(State or country)

Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

records of Md. H. C.

(Address)

15

Filed

August 22nd 1915

L. H. & H. H. H. Local REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug

22

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 9, 1915, to Aug 22, 1915;

that I last saw him alive on Aug 21, 1915

and that death occurred on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. — mos. — ds.

Contributory
Secondary

(Duration) — yrs. — mos. — ds.

(Signed)

O. H. M. Newman

M. D.

Aug 22, 1915 (Address)

Odenton Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 2 mos. 26 ds. In the State yrs. — mos. — ds.

Where was disease contracted, Not known

If not at place of death?

Former or usual residence. Home ad

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Md.

August 23rd 1915

20 UNDERTAKER

ADDRESS

Wm Cook

Baltimore Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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REC'D
SEP 3 1915
BUREAU, U.S.

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1 PLACE OF DEATH

13100

County A.A. Md.Village or City S. Baltimore (No. 19 Siper)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 24

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Wanda Gosztutic

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH Feb. 2, 1914
(Month) (Day) (Year)7 AGE 1 yrs. 5 mos. 5 ds. If LESS than 1 day.....hrs. OR.....min. ?8 OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant9 BIRTHPLACE (State or country) Cherokits bay10 NAME OF FATHER Wicenty Gosztutic11 BIRTHPLACE OF FATHER (State or country) Russia12 MAIDEN NAME OF MOTHER Michalina Szwabowicz13 BIRTHPLACE OF MOTHER (State or country) Russian

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wicenty Gosztutic(Address) 30 Balto. Md.15 Aug 8th 1915 J.B. Horton Md.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 7, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 25, 1915 to Aug 5, 1915, that I last saw h. or alive on Aug 5, 1915and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Enteritis(Duration) 15 ds.Contributory
Secondary(Signed) A. J. Freedom M. D.
Aug 8, 1915 (Address) 918 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL St. Stanislaus DATE OF BURIAL Aug 9, 191520 UNDERTAKER William F. All/wood ADDRESS 1618 Eastern Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

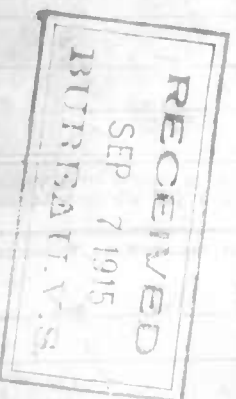
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

a a

13101

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Annapolis

(No.

Gloucester

St.; 2 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Louise Harmon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

Widow

6 DATE OF BIRTH

Unknown

7 AGE

About 70

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Annapolis Md

10 NAME OF FATHER

Solomon Trazier

11 BIRTHPLACE OF FATHER

Maine

12 MAIDEN NAME OF MOTHER

Elizabeth Hubbard

13 BIRTHPLACE OF MOTHER

Annapolis Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. Conway

(Address)

Gloucester St
Annapolis Md

15

Filed

Aug 31, 1915 - Mrs. Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

8 30, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 11, 1915, to Aug 30, 1915,

that I last saw him alive on Aug 29, 1915,

and that death occurred on the date stated above, at 30 m.

The CAUSE OF DEATH * was as follows:

C. M. P. H. S.

(Duration) / yrs. mos. ds.

Contributory

Secondary

(Duration) / yrs. mos. ds.

(Signed)

J. J. Murphy, M. D.

1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Bluff Cemetery Sept 1, 1915

20 UNDERTAKER

ADDRESS

James A. Taylor Annapolis

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
SEP 7 1915
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

13145

County

a-a-

Village or City

St Margarets

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Rogers Henson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colord

5 SINGLE,

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Jan - 23, 1880

(Month)

(Day)

(Year)

7 AGE

29 yrs. 6 mos. 20 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

a-a- Co Md

10 NAME OF FATHER

John Henson

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

a-a- Co Md

12 MAIDEN NAME OF MOTHER

Elizabeth Porter

13 BIRTHPLACE OF MOTHER

(State or country)

a-a- Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Porter

(Address)

St Margarets P.O.

15

Filed

Aug 14, 1915 Wm Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 12, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 26, 1915, to Aug 12, 1915,

that I last saw him alive on Aug 10, 1915,

and that death occurred on the date stated above, at 9:30 am.

The CAUSE OF DEATH * was as follows:

Chronic Peritonitis

(Duration) yrs. 5 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. L. Ridout M. D.
Aug 13, 1915 (Address) Annapolis Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Broad Neck Cmt. 8 14, 1915

20 UNDERTAKER

ADDRESS

E H B Parker & Son 92 West St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Trocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same term for the same disease. Examples: *Cerebrost fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rewolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

SEP 7 1915

BUREAU U. S. A.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

a a

13102

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Annapolis

(No. 17)

College ave

St. 1

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Gertrude Lora Hoffman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Sept 22

(Month)

(Day)

1882 (Year)

7 AGE

32

yrs. 11

mos. 7

ds.

It LESS than

1 day.....hrs.

OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore N. J.

10 NAME OF FATHER

John Powell

11 BIRTHPLACE OF FATHER

(State or country)

Baltimore N. J.

12 MAIDEN NAME OF MOTHER

Laurie Larny

13 BIRTHPLACE OF MOTHER

(State or country)

Salem N. J.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. L. Hoffman

(Address)

17 College ave

15

Filed

Aug 31, 1915

Wm S Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug

29

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

March

1915

to

August

1915

that I last saw her alive on

Aug 29

1915

and that death occurred on the date stated above, at 10:15 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus
General Carcinomatosis

(Duration) 1 yrs. 6 mos. ds.

Contributory
Secondary

(Duration).....yrs.....mos.....ds.

(Signed)

J. A. Bax

M. D.

(Address)

Annapolis Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Philadelphia Pa

8/30, 1915

20 UNDERTAKER

ADDRESS

Bent's Hopping

Annapolis Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

SEP 7 1915

DEPT. OF HEALTH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 13103

County

a-a-

Village or City

Camp Parole

(No.

St.; Ward)

Registration Dist. No.

21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Arnetta Jennings

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Nov-15-1914

(Month)

(Day)

(Year)

7 AGE

8 21

yrs.

mos.

ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Camp Parole, Md

PARENTS

10 NAME OF FATHER

Louis Jennings

11 BIRTHPLACE OF FATHER

(State or country)

Annapolis Md

12 MAIDEN NAME OF MOTHER

Mary Snowden

13 BIRTHPLACE OF MOTHER

(State or country)

South River Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis Jennings

(Address)

P.O. Camp Parole Md

15

Filed

Aug 6, 1915 - Mrs Welch

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 5th, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 30th, 1915 to August 5th, 1915

that I last saw her alive on August 5th, 1915

and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Dementia
Meningitis

(Duration)

yrs.

mos.

ds.

Contributory
Secondary

Exhaustion

(Duration)

yrs.

mos.

ds.

(Signed) John Ridout, M. D.

August 5th, 1915 (Address) Annapolis

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brewerhill Cmt - 8. 7. 1915

20 UNDERTAKER

ADDRESS

E. H. B. Parker & son 92 West St

Ridout

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

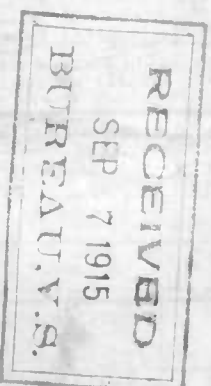
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 21

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

Married.

6 DATE OF BIRTH

May ninth, 1874
(Month) (Day) (Year)

7 AGE

41 yrs. 3 mos. 4 ds. If LESS than
1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Janitor

9 BIRTHPLACE

(State or country)

Anne Arundel Co.

10 NAME OF FATHER

Thomas H. Jennings

11 BIRTHPLACE OF FATHER

(State or country) Anne Arundel Co.

12 MAIDEN NAME OF MOTHER

Georgie Dodson

13 BIRTHPLACE OF MOTHER

(State or country) Anne Arundel Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. Austin Keane

(Address)

Earleigh Hpts.

15

Filed

Aug 14, 1915

Thomas N. Bragshaw

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 13th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

1915, to 1915,

that I last saw him alive on 1915,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Carcinoma of intestines

(Duration) yrs. 6 mos. - ds.

Contributory
Secondary

Jaundice & fall from stairs

(Duration) yrs. 3 mos. - ds.

(Signed)

Thomas H. Bragshaw, M. D.

Aug 14, 1915 (Address) Earleigh Hpts.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Town Neck Cmt., 8. 15, 1915

20 UNDERTAKER

ADDRESS

E. H. B. Parker & Son 92 West St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, periantrum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Raclober wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
SEP 7 1915
BUREAU OF

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

13105

County

Anne Arundel

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 21

Village or City

Marley

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James William Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

October

14th

1914

(Month)

(Day)

(Year)

7 AGE

yrs. 10

mos. —

ds.

It LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Marley A. A. Co Md

PARENTS

10 NAME OF FATHER

James Thomas Johnson

11 BIRTHPLACE OF FATHER
(State or country)

Marley A. A. Co

12 MAIDEN NAME OF MOTHER

Mary A. Bland

13 BIRTHPLACE OF MOTHER
(State or country)

Patapsco Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Thomas Johnson Father

(Address)

Marley A. A. Co

15

Filed

Aug 2

1915

J. S. Bellinger

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug

1

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191...., to

191....

that I last saw him alive on 191....

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Summer Complaint

Certificate signed by (Duration) yrs. 1 mos. ds.

Contributory
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

James S. Bellinger, M. D.

(Address)

Elkton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

to the

State

yrs.

mos.

ds.

Where was disease contracted,
If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Furnace Branch

Aug 2, 1915

20 UNDERTAKER

ADDRESS

Amstoring Henry

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

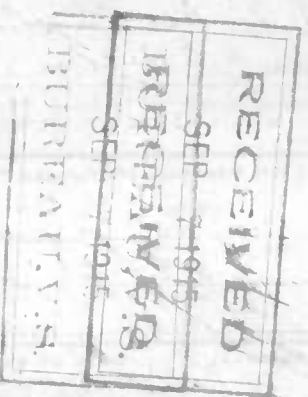
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not finally employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Anne ArundelVillage or City Crownsville State Hospital

2 FULL NAME

Daisy Jones

13106

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Unknown, 1897
(Month) (Day) (Year)

7 AGE 18 yrs. X mos. X ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Isaac Jones
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Sallie Morris
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records
(Address) Crownsville Md.

15 8/6, 1915
Filed. D. E. Jones
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 2, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1914, to Aug. 2, 1915, that I last saw her alive on Aug. 2, 1915, and that death occurred on the date stated above, at 7:30 am

The CAUSE OF DEATH * was as follows:

Tubercular peritonitis(Duration) X yrs. 2 mos. X ds.Contributory Pulmonary Tuberculosis
Secondary

(Signed) D. E. Jones (Duration) unknown yrs. 0 mos. 0 ds.
Aug 5, 1915 (Address) Crownsville Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 0 mos. 1 ds. In the Since birth State, 0 yrs. 0 mos. 0 ds.
Where was disease contracted,
If not at place of death?

Former or usual residence: Bishops, Worcester County

19 PLACE OF BURIAL OR REMOVAL Hospital Cemetery DATE OF BURIAL 8/6, 1915

20 UNDERTAKER R. P. Winkler ADDRESS Waterbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trama," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Racloir wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>a-a-</u> 13107		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>East Port</u> (No. <u>5</u>)		Registration Dist. No. <u>21</u> Ward	
2 FULL NAME <u>Eliza Ann Jones</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colord</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widow</u> (Write the word)	
6 DATE OF BIRTH <u>Jan - 11</u> 18 <u>93</u> (Month) (Day) (Year)			
7 AGE <u>68</u> yrs. <u>8</u> mos. <u>7</u> ds.		If LESS than 1 day. hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Domestic</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>at Home</u>			
9 BIRTHPLACE (State or country) <u>a-a- Co Md.</u>			
PARENTS	10 NAME OF FATHER <u>Thomas Sellman</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>a-a- Co Md.</u>		
	12 MAIDEN NAME OF MOTHER <u>Eliza Parker</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>a-a- Co Md.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Samuel Jones</u> (Address) <u>5 Street</u>			
15 <u>Aug 23</u> , 191 <u>5</u> <u>Jms Welch</u> Filed REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>August 20</u> , 191 <u>5</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>on Aug 3</u> , 191 <u>5</u> , to <u>August 3</u> , 191 <u>5</u> , that I last saw her alive on <u>August 3</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>6:57</u> m.			
The CAUSE OF DEATH * was as follows: <u>Carcinoma of Lower Jaw</u> (Duration) — yrs. <u>11</u> mos. ds.			
Contributory Secondary <u>Ambrose Garcia</u> (Duration) yrs. mos. ds. (Signed) <u>8-22-1915</u> (Address) <u>Anna John's Mt</u> M. O.			
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Brewerhill Cemt</u>		DATE OF BURIAL <u>8-23</u> , 191 <u>5</u>	
20 UNDERTAKER <u>E H B Parker & Son</u>		ADDRESS <u>82 West St</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

ges, peritoneum, etc., Carcinoma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Reckless wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
SEP 7 1915
BUREAU U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

13108

County

a d

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

22

Village or City

Gump

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Julious Keys

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

married

6 DATE OF BIRTH

unknown

(Month)

(Day)

(Year)

7 AGE

64

yrs.

mos.

ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

md

10 NAME OF FATHER

Julious Keys

11 BIRTHPLACE OF FATHER

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER

(State or country)

unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Agnes Eads

(Address)

Gump md

15

Filed

August 12 1915 L H & H Ashup

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 9

(Month)

11

(Day)

1915

(Year)

I HEREBY CERTIFY, That I attended deceased from

June 1st 1915, to Aug 11 1915,

that I last saw him alive on Aug 10 1915,

and that death occurred on the date stated above, at 6:15 am.

The CAUSE OF DEATH was as follows:

Chronic endo-carditis

(Duration) 2 yrs. — mos. — ds.

Contributory
Secondary

(Duration) yrs. mos. da.

(Signed)

R. A. Hammond, M. D.

Aug 12 1915 (Address) Gump Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

in the

of death yrs. moa. ds.

State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Portland

Aug 13, 1915

20 UNDERTAKER

ADDRESS

Fisher & Chair

Laurel Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Electrician*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Doctor," etc., without more precise specification as *Day laborer*, *Furnace laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mesles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collyse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>AA</u>		13109		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Waterbury</u> (No. <u>79</u>)		St. <u>79</u> Ward <u>7</u>		Registration Dist. No. <u>61</u>	
2 FULL NAME <u>Wm. J. Samsel</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>OR</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>	18 DATE OF DEATH <u>8</u> <u>2</u> , 191 <u>5</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>unknown</u> (Month) (Day) (Year) <u>1846</u>			17 I HEREBY CERTIFY, That I attended deceased from <u>7-28</u> , 191 <u>5</u> , to <u>8-2</u> , 191 <u>5</u> , that I last saw him alive on <u>8-1</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>84</u> m. The CAUSE OF DEATH* was as follows: <u>Myocarditis</u>		
7 AGE <u>69</u> yrs. <u>6</u> mos. <u>0</u> ds. OR <u>0</u> min. ?			Contributory (Secondary) <u>Arteriosclerosis</u> (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Widow</u> (b) General nature of industry, business, or establishment in which employed (or employer)			(Signed) <u>A. B. Yarnall</u> , M. D. <u>8-2</u> , 191 <u>5</u> . (Address) <u>W. H. H. H. H.</u>		
9 BIRTHPLACE (State or country) <u>Ind</u>			*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
10 NAME OF FATHER <u>James Tucker</u>			18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u>0</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Calvert Co Ind</u>			19 PLACE OF BURIAL OR REMOVAL <u>Baldwin Mason Cemetery</u>		
12 MAIDEN NAME OF MOTHER <u>Mary Tucker</u>			DATE OF BURIAL <u>8/4</u> , 191 <u>5</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Calvert Co Ind</u>			20 UNDERTAKER <u>B. H. Williams & Son</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alice M. Wilson</u> (Address) <u>Waterbury Ind</u>			ADDRESS <u>Waterbury Md</u>		
15 Filed <u>8/3</u> , 191 <u>5</u> <u>W. H. H. H. H.</u> REGISTRAR					
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Transition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
SEP 7 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

131110

County

Village or City

(No.)

Registration Dist. No.

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*
(Write the word)

6 DATE OF BIRTH *unknown*
(Month) (Day) (Year)

7 AGE *22* yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work *Sailor*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Sweden*

10 NAME OF FATHER *unknown*

11 BIRTHPLACE OF FATHER (State or country) *Sweden*

12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (State or country) *unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Aug 1st*, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from
191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
(Duration) yrs. mos. ds.

Contributory Secondary

(Signed) *James F. Fowler*
Aug 2nd, 1915 (Address) *Brooklyn*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cedar Hill Cemetery Aug 2nd, 1915

20 UNDERTAKER ADDRESS

Armstrong Denny B 719 Light St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

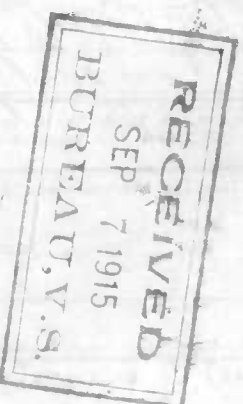
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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scific," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 13111		STATE OF MARYLAND	
County <u>Anne Arundel Co.</u>		CERTIFICATE OF DEATH	
Village or City <u>Smigler</u> (No. <u>Anne Arundel Co.</u> St. <u> </u> Ward <u> </u>)		Registration Dist. No. <u>21</u>	
2 FULL NAME <u>William Leman</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>Feb 16th</u> , 18 <u>32</u> (Month) (Day) (Year)			
7 AGE <u>83</u> yrs. <u>5</u> mos. <u>15</u> ds.		If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Shoemaker</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Retired</u>			
9 BIRTHPLACE (State or country) <u>Scotland</u>			
PARENTS	10 NAME OF FATHER <u>John W. Leman</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Scotland</u>		
	12 MAIDEN NAME OF MOTHER <u>Barbara Brodie</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Scotland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary L. E. Hauman</u> (Address) <u>Smigler Md.</u>			
15 Filled <u>Aug 1</u> , 191 <u>5</u> <u>J. S. Beelings</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Aug. 1st</u> , 191 <u>5</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan.</u> , 191 <u>5</u> , to <u>Aug 1</u> , 191 <u>5</u> , that I last saw him alive on <u>July 21</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>3³⁰</u> A. M., The CAUSE OF DEATH* was as follows: <u>Myocardial Insufficiency</u> (Duration) <u>5</u> yrs. <u> </u> mos. <u> </u> ds. Contributory _____ Secondary _____ (Signed) <u>J. S. Beelings</u> , M. D. <u>Aug 1</u> , 191 <u>5</u> (Address) <u>Elvaton Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>London Park Cemetery</u>		DATE OF BURIAL <u>Aug 3rd</u> , 191 <u>5</u>	
20 UNDERTAKER <u>Wm. & Mrs. John W. Seufel</u>		ADDRESS <u>801 W. Fayette St.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

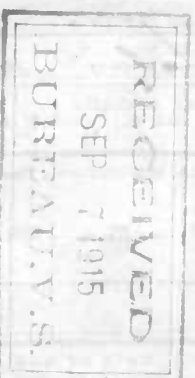
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1 PLACE OF DEATH

13112

County

A A

Village or City

Annapolis
U. S. Naval HospitalSTATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Alexander Hugh McCormick

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED, WIDOWER
OR DIVORCED
(Write the word)

Widower

6 DATE OF BIRTH

May 9, 1892
(Month) (Day) (Year)

7 AGE

73 yrs. 3 mos. 12 ds.
If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Rear Admiral U. S. N.

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Washington D. C.

10 NAME OF FATHER

Alexander McCormick

11 BIRTHPLACE OF FATHER

Washington D. C.

12 MAIDEN NAME OF MOTHER

Eliza Van Horn

13 BIRTHPLACE OF MOTHER

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Howard McCormick
18 West St
Annapolis Md.

(Address)

15

Filed Aug 23, 1915

J. S. Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 21, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 8, 1915, to Aug. 21, 1915,
that I last saw him alive on Aug 21, 1915,
and that death occurred on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH * was as follows:

Chronic interstitial nephritis

(Duration) 6 yrs. mos. ds.

Contributory
Secondaryarterio-sclerosis
about 10 yrs. mos. ds.

(Signed)

J. S. Welch
1915
Address Naval Hospital, Annapolis Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 mos. 13 ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D. C. Aug 24, 1915

20 UNDERTAKER

ADDRESS

Jas. S. Taylor Sons Annapolis Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *ACCIDENTAL*, *SUICIDAL*, or *HOMICIDAL*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 7 1915

BOSTON, U.S.A.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

13113

County

a a

Village or City

Mellersville

(No.

Registration Dist. No.

22

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Martha Elizabeth McKnew

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE white
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single
6 DATE OF BIRTH July 26, 1915
(Month) (Day) (Year)
7 AGE 16 yrs. 16 mos. 16 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Mellersville

PARENTS

10 NAME OF FATHER

C. H. McKnew

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Martha Murray

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. H. McKnew

(Address)

Mellersville Md

15

Filed

Aug 11, 1915 Holiday

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 11th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 26, 1915, to Aug 11th, 1915
that last saw her alive on Aug 9, 1915

and that death occurred on the date stated above, at 12:30 pm.

The CAUSE OF DEATH* was as follows:

Perinatal birth

(Duration) yrs. mos. 16 ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

C. H. McKnew

M. D.

July 11, 1915 (Address) Odenton Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Odenton Md

Aug 12, 1915

20 UNDERTAKER

ADDRESS

R. J. Williams & Son

Waterbury

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

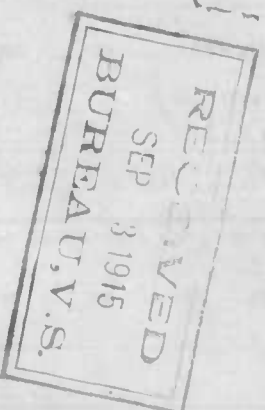
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report, "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Anne Arundel</u>		13114		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Elkton</u>		(No. _____)		Registration Dist. No. <u>21</u>	
2 FULL NAME <u>Buriah Matthews</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Infant</u> (Write the word)			
6 DATE OF BIRTH <u>April</u> , 1915 (Month) (Day) (Year)					
7 AGE yrs. <u>4</u> mos. _____ ds.		It LESS than 1 day, _____ hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>John Matthews</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Jane Dorsey</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>John Matthews</u>					
(Address) <u>Elkton</u>					
15 Filed <u>Aug 24</u> , 1915 <u>Thomas A. Graydon</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Aug</u> , <u>23</u> , 1915 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>was dead</u> , 1915, to <u>Dec 10</u> , 1915, that I last saw him _____ alive on _____, 1915, and that death occurred on the date stated above, at <u>6 P.</u> m. The CAUSE OF DEATH * was as follows:					
<u>Enteroviret</u> (Duration) _____ yrs. _____ mos. <u>4</u> ds.					
Contributory Secondary _____					
(Signed) <u>Thomas A. Graydon</u> , M. D. <u>Aug 24</u> , 1915 (Address) <u>Elkton</u>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In this State, _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Magrath</u>				DATE OF BURIAL <u>Aug 24</u> , 1915	
20 UNDERTAKER <u>Samuel Allen</u>				ADDRESS <u>Annapolis</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

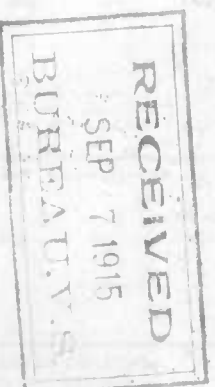
[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reinher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

13115

County

A. A.

Village or City

Glen Burnie

(No.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

23

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thomas Brayshaw Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

S.

6 DATE OF BIRTH

May 7, 1915
(Month) (Day) (Year)

7 AGE

3 yrs. 3 mos. 3 ds.

If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

A. A. Co.

10 NAME OF FATHER

John E. Miller

11 BIRTHPLACE OF FATHER (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Laura A. Burgess

13 BIRTHPLACE OF MOTHER (State or country)

Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Miller

(Address)

Glen Burnie

15

Filed

8/11

1915

T. H. Brayshaw

Dep. Reg.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 10th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug. 8th, 1915, to Aug. 10, 1915,
that I last saw him alive on Aug. 9, 1915,
and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH * was as follows:

Marasmus

(Duration) yrs. 3 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

M. J. Mornell

M. D.

8/10, 1915 (Address) Glen Burnie, Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Tubbs Burying Ground

8/11, 1915

20 UNDERTAKER

ADDRESS

Balto.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED
MAY 4 1915
BUREAU, V.S.

RECEIVED
MAY 6 1915
BUREAU, V.S.

sent out to be signed
in ink.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>U. T. Co.</u>		13116		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Castport</u> (No. <u>104</u>)		St.; Ward		Registration Dist. No. <u>21</u>	
2 FULL NAME <u>Chas. O. Mitchell</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>single</u> (Write the word)			
6 DATE OF BIRTH <u>June 4, 1915</u> (Month) (Day) (Year)					
7 AGE <u>2</u> yrs. <u>6</u> mos. <u>6</u> ds.		If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Castport Md</u>					
PARENTS	10 NAME OF FATHER <u>Philip Mitchell</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Castport Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Elsie Downiss</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Lansel Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Philip Mitchell</u> (Address) <u>Castport</u>					
15 Filed <u>Aug 9, 1915</u> <u>Jms Welch</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>8</u> <u>8</u> , 191 <u>5</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 1st</u> , 191 <u>5</u> , to <u>Aug 8</u> , 191 <u>5</u> , that I last saw him alive on <u>Aug 7</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>7a</u> m. The CAUSE OF DEATH * was as follows: <u>M. A. S. S. S.</u> (Duration) yrs. <u>1</u> mos. <u>6</u> ds. Contributory <u>Enterocolitis</u> Secondary (Signed) <u>J. J. Murphy</u> , M. D. , 191 <u>5</u> (Address) <u>Annaboli</u>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. <u>6</u> mos. <u>6</u> ds. In the State, yrs. <u>6</u> mos. <u>6</u> ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>H. Amies Cem.</u>				DATE OF BURIAL <u>8/6</u> , 191 <u>5</u>	
20 UNDERTAKER <u>Woolley & Son</u>				ADDRESS <u>12 Murray Ave.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 7 1915

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Anne Arundel</u>		13117		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Wardour</u> (No. <u>169</u>)		St. <u>Ward</u>		Registration Dist. No. <u>21</u>	
2 FULL NAME <u>John Morrow</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Widower</u> (Write the word)			
6 DATE OF BIRTH <u>Unknown</u> , 1 (Year) (Month) (Day)					
7 AGE <u>about 69</u> yrs. mos. ds.		If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Plaster</u> (b) General nature of industry business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Baltimore Md</u>					
PARENTS	10 NAME OF FATHER <u>Unknown</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>				
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (informant) <u>Jas S Taylor, Sons</u> (Address) <u>Annapolis</u>					
15 Filed <u>Aug 13, 1915</u> <u>WMS Welch</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Aug 10, 1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Accidental Drowning</u> (Duration) yrs. mos. ds.					
Contributory Secondary					
(Signed) <u>William J. Myrick, Grover</u> <u>Aug 13, 1915</u> (Address) <u>Annapolis Maryland</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Baltimore Md</u>				DATE OF BURIAL <u>Aug 13, 1915</u>	
20 UNDERTAKER <u>Jas S Taylor, Sons</u>				ADDRESS <u>Annapolis</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Vocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy" ("Col-lapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
SEP 7 1915
BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

131118

County

A. A.

Village or City

Jessups

(No.)

Registration Dist. No.

25

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Melvin Myers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, X
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

1863
(Month) (Day) (Year)

7 AGE

52

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Labour, on farm.

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Not Known

PARENTS

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER

(State or country)

Not Known

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER

(State or country)

Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Aug 31st, 1915 L H P Hashbarger
Local REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 31, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 3, 1915 to Aug 31, 1915

that I last saw him alive on Aug 31, 1915

and that death occurred on the date stated above, at 7-15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

John C. Woodland, M. D.

Aug 31, 1915 (Address) Jessups Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 3 mos. 8 ds. In the State yrs. mos. ds.

Where was disease contracted, Not Known
If not at place of death?

Former or usual residence Not Aug, Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount-Ring Md Sept-2nd, 1915

20 UNDERTAKER

ADDRESS

Bowman & Bros Mount-Ring Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thema," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
SEP 31 1915
BURIALITY

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

13119

County

G. G.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

24

Village or City

So. Balt.

(No. 112)

Express

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Leon Frank Olzit

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Infant

6 DATE OF BIRTH

May 31, 1914

7 AGE

1 yrs. 2 mos. 4 ds.

It LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

So. Balt.

PARENTS

10 NAME OF FATHER

Leon Olzit

11 BIRTHPLACE OF FATHER (State or country)

Custria

12 MAIDEN NAME OF MOTHER

Frances Mitnick

13 BIRTHPLACE OF MOTHER (State or country)

Custria

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leon Olzit

(Address)

112 Express St

15

Filed

Aug 4, 1915

J. B. Horton

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug. 4th, 1915

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 9th, 1915, to Aug 4th, 1915.

that I last saw him alive on July 31st, 1915.

and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis.

(Duration) yrs. mos. 26 ds.

Contributory Secondary

Malnutrition

(Duration) yrs. mos. 14 ds.

(Signed)

Geo B Davis

M. D.

Aug 4th, 1915 (Address) Custria, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross

Aug 9, 1915

20 UNDERTAKER

ADDRESS

Frank Crocker Son 1804-6 Westland

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

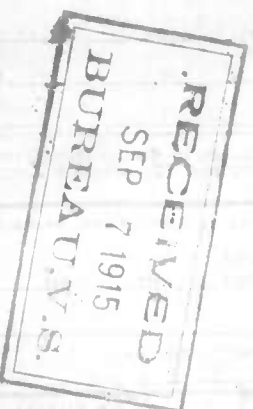
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

13120

County

Anne Arundel

Village or City

Brooklyn

(No.

101

St.

Registration Dist. No.

25

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ann Elizabeth Ormen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 27, 1877
(Month) (Day) (Year)

7 AGE 38 yrs. — 22 mos. — 22 ds. If LESS than 1 day, hrs. OR mo. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work house
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto. Md.

10 NAME OF FATHER John F. Ormen

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Forster

13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl G. Weibking

(Address) 101-6 St. Brooklyn

15 Filed Aug 20, 1915 Charles B. Cook

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1915, to Aug 18, 1915

that I last saw him alive on Aug 18, 1915

and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal
reptition

(Duration) yrs. 3 mos. ds.

Contributory Chronic Constipation
(Secondary)

(Duration) yrs. 3 mos. ds.

(Signed) Charles B. Cook M. D.

Aug 20, 1915 (Address) 835 1/2 St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Linden Park Bur. Aug 21, 1915

20 UNDERTAKER ADDRESS

Joseph B. Cook 1003 W. Balto

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

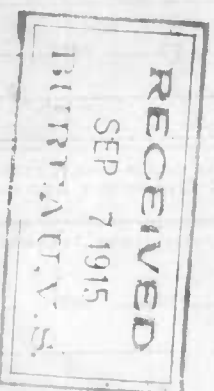
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; *Cancer* is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Nanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



13121

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Anne ArundelVillage or City Traces Landing (No. _____) St.; _____ Ward)2 FULL NAME Susie Parks

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single
(Write the word)6 DATE OF BIRTH May 15, 1898
(Month) (Day) (Year)7 AGE 17 yrs. 3 mos. 9 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework until 1 year ago,
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Md.10 NAME OF FATHER George C. Parks11 BIRTHPLACE OF FATHER (State or country) Md.12 MAIDEN NAME OF MOTHER Margaret Paddy13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. C. Parks,(Address) Traces Landing15 Filed Aug. 25, 1915 A. H. Perrie
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 24, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY That I attended deceased from May, 1915, to Aug. 24, 1915.that I last saw her alive on Aug. 23, 1915.and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) 1 yrs. ____ mos. ____ ds.Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. H. Perrie M. D.
Aug. 25, 1915 (Address) McKendrick, Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. to the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Friendship, Md. DATE OF BURIAL Aug. 25, 191520 UNDERTAKER Robt. J. Wood ADDRESS Friendship, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

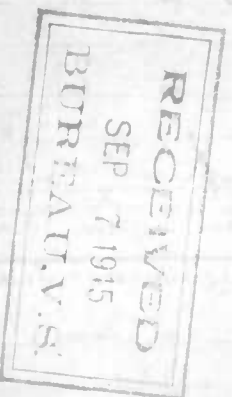
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Idantion," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Village or City

(No.)

St.; Ward)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day, 1 hr. 1
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

PARENTS

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
Secondary

(Signed)

Aug. 8, 1915

(Address)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

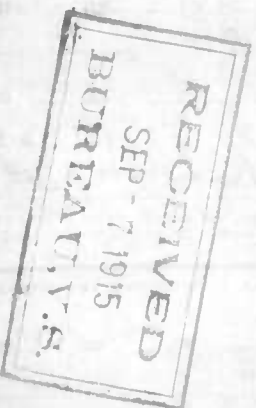
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Anne Arundel
Village or City Annapolis (No. 79)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Roster Pickney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH unknown, 1879
(Month) (Day) (Year)

7 AGE 36 yrs. mos. ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9 BIRTHPLACE (State or country) Anne Arundel Md

10 NAME OF FATHER John Wallace

11 BIRTHPLACE OF FATHER (State or country) Prince George Co. Md

12 MAIDEN NAME OF MOTHER Ellen Hall

13 BIRTHPLACE OF MOTHER (State or country) Anne Arundel County Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) St Marys Cemetery

(Address) St Marys Cemetery

15 Filed Aug 18, 1915 Wm S Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Aug 16, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1915, to Aug 16, 1915, that I last saw her alive on Aug 15, 1915

and that death occurred on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:

Acute valvular heart disease
(Duration) yrs. mos. 30 ds.

Contributory (Secondary) Chronic bronchitis
(Duration) yrs. mos. 6 mos. 16 ds.

(Signed) Harold L. Howard, M. D.
Aug 17, 1915 (Address) 80 Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Marys Cemetery DATE OF BURIAL 8 18, 1915

20 UNDERTAKER Wm S Welch ADDRESS 16 Calvert St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

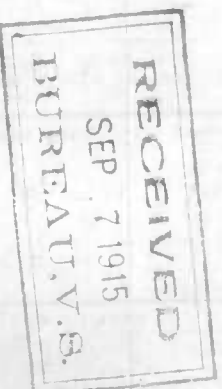
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

13124

104

1 PLACE OF DEATH
County Anne Arundel

Village or City Dzale (No. _____) St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Flora Virginia Pratt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
6 DATE OF BIRTH <u>Unknown</u> , 191 <u>5</u> (Month) (Day) (Year)		
7 AGE <u>about</u> <u>0</u> yrs. <u>2</u> mos. _____ ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Md.</u>		
PARENTS	10 NAME OF FATHER <u>Ollie Pratt</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>	
	12 MAIDEN NAME OF MOTHER <u>Barbara Gross</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ollie Pratt
(Address) Dzale Md.

15 Filed Aug. 12, 1915 A. H. Terrie
Dzale REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 26

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 11, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1915, to Aug. 11, 1915.

that I last saw him alive on Aug. 10, 1915.

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) _____ yrs. _____ mos. 5 ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. H. Terrie, M. D.
Aug. 12, 1915 (Address) McKendree, Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Friendship Md. DATE OF BURIAL Aug. 12, 1915

20 UNDERTAKER - John Taylor ADDRESS Nutwell, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

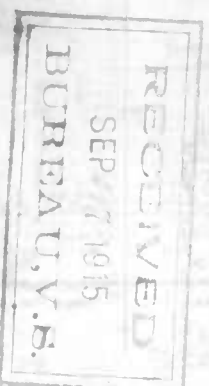
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congital," "Seuile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

13125

County

Anne Arundel

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Crownsville, State Hospital, Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Wesley Price

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Unknown, 1883
(Month) (Day) (Year)

7 AGE

32 Unknown
yrs. mos. ds.If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Leven J Price

11 BIRTHPLACE OF FATHER

Maryland

12 MAIDEN NAME OF MOTHER

Pleasant Beckett

13 BIRTHPLACE OF MOTHER

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital

(Address)

Records

15

Filed

8/12, 1915
S. P. Joyce
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 11, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Sept 7, 1914, to Aug 11, 1915that I last saw h e alive on Aug 11, 1915,
and that death occurred on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH * was as follows:

Cerebral abscess

Contributory
SecondaryUnknown
(Duration) yrs. mos. ds.(Signed) Robert D. Minter, M.D.
Aug 11, 1915 (Address) Crownsville Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 11 mos. 4 ds. to the State, yrs. Life mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Worcester County

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hospital Cemetery Aug 12, 1915

20 UNDERTAKER

ADDRESS

R. P. Winkler, Supt. Walsby, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

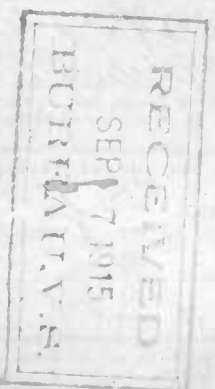
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Conrenal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 13126
County Ches. Anndel

Village or City Drury (No.)

2 FULL NAME Pumphrey

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 26

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 8 7 1915
(Month) (Day) (Year)

7 AGE 11 yrs. 6 mos. 1 ds. OR 1 day, 1 hrs. 1 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John W. Pumphrey

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maryland Powell

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Powell

(Address) Drury, Md.

15 Filed Aug. 8, 1915 A. H. Perrie
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 8, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1915 to August 8, 1915

that I last saw him alive on, 1915

and that death occurred on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Reverdy J. Jones, M. D.

August 8, 1915 (Address) up. Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL near Drury, P.D. DATE OF BURIAL Aug. 8, 1915

20 UNDERTAKER W. O. Welch ADDRESS Bristol, Md.

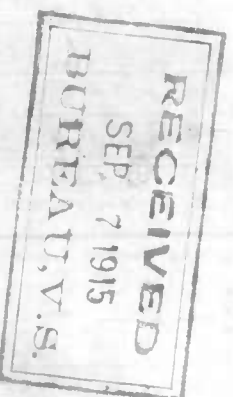
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salcman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Turn laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 13127
 County A-A-
 Village or City Annapolis (No. 202, Lincoln Place, 4 St.; 4 Ward) Registration Dist. No. 21
 2 FULL NAME Infant - Richardson

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Aug. 16, 1915
 (Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Annapolis Md.

PARENTS
 10 NAME OF FATHER Jerry Richardson
 11 BIRTHPLACE OF FATHER (State or country) Annapolis Pa.
 12 MAIDEN NAME OF MOTHER Kate Kimble
 13 BIRTHPLACE OF MOTHER (State or country) Annapolis Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Jerry Richardson
 (Address) 202 Lincoln Place

15 Filed Aug 10, 1915 Jms Welch
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 7, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h. _____ alive on _____, 191____,

and that death occurred on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:
Collapse of the lungs

(Duration) _____ yrs. _____ mos. 1 ds.

Contributory _____
 Secondary _____

(Signed) William F. Munnick Coroner
Aug 10, 1915 (Address) Annapolis Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Asbury Cemt. DATE OF BURIAL 8, 1915

20 UNDERTAKER E. H. Barker & Son ADDRESS 92 West St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

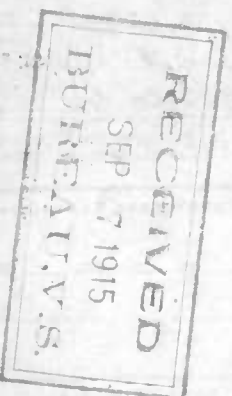
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecasles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecasles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Anne ArundelVillage or City Solley(No. 104)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 24

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph Ross

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

B.

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Dec 7, 1914
(Month) (Day) (Year)

7 AGE

9 yrs. 9 mos. 11 ds.
If LESS than 1 day... hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Anne Arundel Co

10 NAME OF FATHER

John Ross

11 BIRTHPLACE OF FATHER

(State or country)

Ind

12 MAIDEN NAME OF MOTHER

Eleanora Miller

13 BIRTHPLACE OF MOTHER

(State or country)

Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Richard Miller

(Address)

Solley Ind

15

Filed

Aug 18th 1915
J. B. Keeton Md

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 18, 1915, to Aug. 18th, 1915,
that I last saw him alive on Aug. 15th, 1915,and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH was as follows:

Chronic Gastro-Enteritis.(Duration) 7 yrs. 7 mos. 7 ds.

Contributory

Secondary

(Duration) 7 yrs. 7 mos. 7 ds.

(Signed)

William W. J. C. M. D.Aug 18, 1915 (Address) Chertsey Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 7 yrs. 7 mos. 7 ds. In the State, 7 yrs. 7 mos. 7 ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Charley Beck ChurchAUG 18 1915

20 UNDERTAKER

ADDRESS

ARMSTRONG-DENNY CO.715 Light St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

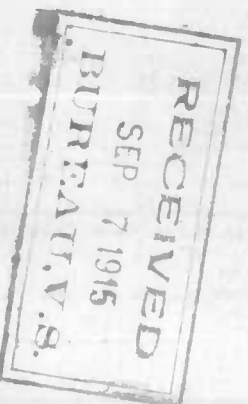
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Tramia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethæus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



13129

1 PLACE OF DEATH

County

A A

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Annapolis (No.

Foot of Pri Geo

St.; 1 Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Jacob Roush

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

Unknown

6 DATE OF BIRTH

Unknown

1

(Month) (Day) (Year)

7 AGE

About 48

It LESS than
1 day, hrs.
OR min.?

yrs. mos. ds.

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Fireman on

(b) General nature of industry
business, or establishment in
which employed (or employer)

Fishing Steamer

9 BIRTHPLACE
(State or country)

Germany

10 NAME OF
FATHER

Unknown

11 BIRTHPLACE
OF FATHER
(State or country)

Unknown

12 MAIDEN NAME
OF MOTHER

Unknown

13 BIRTHPLACE
OF MOTHER
(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lieut. W. Hubbard Capt.

(Address)

Dorothy F. Wacker

15

Filed

Aug 5, 1915

Jas Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug

4

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, that I attended deceased from

191, to 191,

that I last saw him alive on 191,

and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH was as follows:

Accidental drowning

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Wm F. Munnick, Coroner

April 5, 1915

(Address)

Annapolis, Md.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL OR HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State,

yrs.

mos.

ds.

Where was disease contracted,
if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Bluff Cemetery

Aug 5, 1915

20 UNDERTAKER

ADDRESS

Jas S. Day Co. Sons

Annapolis

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a defined salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

gis, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

SEP 7 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Village or City

(No.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDDED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory
Secondary

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Labral pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Riverboat wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

SEP 7 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH

13131

County

A-a-

Village or City

German town 22 Ridouts Row

(No.)

St.; Ward)

Registration Dist. No.

21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Still Infant Simms

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

Colored

SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

DATE OF BIRTH

Aug 7, 1915

AGE

____ yrs. ____ mos. ____ ds.

If LESS than
1 day, ____ hrs.
OR ____ min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(State or country)

German town
Annapolis Md

NAME OF FATHER

Richard Simms

BIRTHPLACE OF FATHER

(State or country)

Salisbury A. & Co Md

MAIDEN NAME OF MOTHER

Priscilla Sarah Robinson

BIRTHPLACE OF MOTHER

(State or country)

Annapolis Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Richard Simms

(Address)

16 Ridouts Row

Filed

Aug 9, 1915 Jms Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

August 7, 1915

17

I HEREBY CERTIFY, That I attended deceased from

____, 191____, to ____ , 191____,
that I last saw him alive on ____ , 191____

and that death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Still birth due to prolapse of
cord five hours before being
seen by Physician

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Walton H. Hopkins, M. D.

Aug 9, 1915 (Address) Annapolis Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Osborns Cemetery

8.9. 1915

20 UNDERTAKER

ADDRESS

E. H. B. Parker & Son 92 West St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Hopkins

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
SEP 7 1915
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

13132

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

24

County Anne ArundelVillage or City Wagner's Point (No. 41, Third Ave. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Harry J. Sines

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Married</u>
----------------------	---------------------------------	---

6 DATE OF BIRTH July 25, 1883
(Month) (Day) (Year)7 AGE 32 yrs. 1 mos. 1 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Fireman (Stationary Engine)
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Alonzo Sines11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Adelaide Busch13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adelaide Sines(Address) Wagner's Point Md.15 Aug 27th 1915 B. Heaton Md.
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Aug 26th 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

AccidentalDrowning
(Duration) ____ yrs. ____ mos. ____ ds.Contributory Secondary
(Signed) James D. Armstrong
Aug 27, 1915 (Address) Brooklyn

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death ? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

CEDAR HILL

DATE OF BURIAL

AUG 30 1915

20 UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Light St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

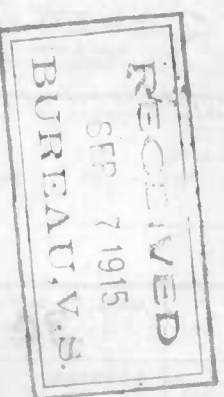
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Trifler engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rancher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Anne Arundel

13133

Village or City Wagner's Point (No. 41 Third Ave.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 24

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Henry Leroy Sines

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH August 18, 1905
(Month) (Day) (Year)

7 AGE 10 yrs. 0 mos. 8 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Maryland

10 NAME OF FATHER Harry J. Sines

11 BIRTHPLACE OF FATHER
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary M. Selie

13 BIRTHPLACE OF MOTHER
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary M. Sines(Address) Wagner's Point Md.

15 Aug 27, 1915 W.B. Horton Md.
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1915, to 1915,

that I last saw him alive on 1915, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Accidental Drowning
(Duration) yrs. mos. ds.

Contributory
Secondary

(Signed) James H. Fowle
Aug 27, 1915 (Address) Brooklyn Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, ICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL CEDAR HILL DATE OF BURIAL AUG 30, 1915

20 UNDERTAKER ARMSTRONG-DENNY CO. ADDRESS 715 Light St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

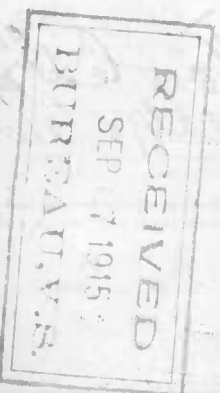
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia."); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH

13134

County

Anne Arundel

Village or City

Hanover

(No.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

23

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Laura Amelia Smith.

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

DATE OF BIRTH

5 17 1840
(Month) (Day) (Year)

AGE

75 yrs. 3 mos. 10 ds. It LESS than 1 day, hrs. OR min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work

General Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country)

Maryland

PARENTS

NAME OF FATHER

Josephus Smith

BIRTHPLACE OF FATHER (State or country)

Maryland

MAIDEN NAME OF MOTHER

Julia Ann Conway

BIRTHPLACE OF MOTHER (State or country)

Maryland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary A. Coursey.

(Address)

Hanover Md

15

Filed....., 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

8 27 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

5/18 1914, to 8/26 1915,

that I last saw her alive on 8/26 1915,

and that death occurred on the date stated above, at 130 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. 2 mos. 9 ds.

Contributory (Secondary)

Mitral Incompetency

(Duration) 6 yrs. 6 mos. 7 ds.

(Signed)

Thos. P. Benson, M. D.

8/27 1915 (Address) Hanover Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs. mos. ds. in the State..... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Family Burying Ground 8/28 1915

20 UNDERTAKER

ADDRESS

J. J. Tiekner Sons Balto Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—(not *mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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RECEIVED
SEP 4 1915
BUREAU, V

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

13135

County Anne ArundelVillage or City South River (No. _____, St.; _____ Ward)

(5) STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 20

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Unnamed infant Spriggs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

Aug 30, 1915
(Month) (Day) (Year)

7 AGE

6 months in utero in gestation
yrs. mos. ds.If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF
FATHERNelson Spriggs11 BIRTHPLACE
OF FATHER
(State or country)Maryland12 MAIDEN NAME
OF MOTHERLucy Brown13 BIRTHPLACE
OF MOTHER
(State or country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ella Brown

(Address)

South River Md

15

Filed Aug 30, 1915John Collinson
Sub. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 30, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Still 191, to born 191,
that I last saw him happened before alive on arrived 191,
and that death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH * was as follows:

Unknown

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory

Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

John Collinson

M. O.

Aug 30, 1915 (Address) South River Md(* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place

of death ____ yrs. ____ mos. ____ ds.

In the

State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

South RiverAug 30, 1915

20 UNDERTAKER

ADDRESS

no undertaker

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

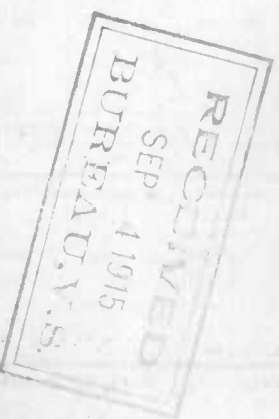
[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

13136

County

aa

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Skidmore

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James William Steiner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widower

6 DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7 AGE

about 80

If LESS than 1 day... hrs. OR... mo. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

A. A. Co. Md

10 NAME OF FATHER

James Steiner

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Nancy Carr

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Allen
at Skidmore A A Co Md

(Address)

15

Filed

Aug 31, 1915

J. W. Steiner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 31, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, that I attended deceased from

Aug 10, 1915

to Aug 31, 1915

that I last saw him alive on Aug 26, 1915

and that death occurred on the date stated above, at 12:30 m.

The CAUSE OF DEATH * was as follows:

Chronic lung disease

(Duration) yrs. 6 mos. de.

Contributory

Secondary

(Duration) yrs. mos. de.

(Signed)

J. C. Taylor M. D.
Aug 31, 1915 (Address) Annapolis

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

de.

In the

State,

yrs.

mos.

de.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Broad creek

Sept 1, 1915

20 UNDERTAKER

ADDRESS

Geo. S. Taylor, Son

Annapolis Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

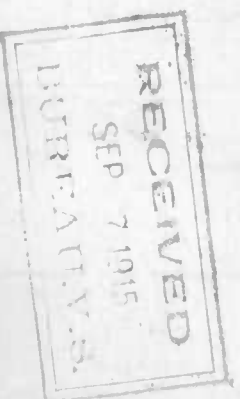
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *ACCIDENTAL*, *SUICIDAL*, or *HOMICIDAL*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>A. A.</u>			13137			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Annapolis</u>			(No. <u>23</u> Collage Ave St.; 1 Ward)			Registration Dist. No. <u>21</u>		
2 FULL NAME <u>John B. Sternberg</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Male</u>		4 COLOR OR RACE <u>White</u>		5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)				
6 DATE OF BIRTH <u>July 15, 1915</u> (Month) (Day) (Year)								
7 AGE <u>6</u> yrs. <u>13</u> mos. <u>13</u> ds.				If LESS than 1 day, ____ hrs. OR ____ mo. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)								
9 BIRTHPLACE (State or country) <u>Annapolis Md</u>								
PARENTS	10 NAME OF FATHER <u>Peter Sternberg</u>							
	11 BIRTHPLACE OF FATHER (State or country) <u>Sweden</u>							
	12 MAIDEN NAME OF MOTHER <u>Julia Taylor</u>							
13 BIRTHPLACE OF MOTHER (State or country) <u>Annapolis Md</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE								
(Informant) <u>Julia Sternberg</u>								
(Address) <u>Annapolis Md</u>								
15 Filed <u>Aug 28, 1915</u> <u>Jms Welch</u> REGISTRAR								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>Aug 26, 1915</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 1st</u> , 1915, to <u>Aug 26th</u> , 1915, that I last saw him alive on <u>Aug 26th</u> , 1915, and that death occurred on the date stated above, at <u>8 P.</u> m.								
The CAUSE OF DEATH * was as follows: <u>Malnutrition</u>								
Contributory <u>Branchitis</u> Secondary								
(Signed) <u>John B. Sternberg</u> M. D. <u>Aug 28th</u> , 1915 (Address) <u>Annapolis Md</u>								
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.								
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the ____ State ____ yrs. ____ mos. ____ ds. Where was disease contracted? If not at place of death? Former or usual residence								
19 PLACE OF BURIAL OR REMOVAL <u>St Marys Revit</u>						DATE OF BURIAL <u>Aug 28, 1915</u>		
20 UNDERTAKER <u>Gas & Taylor Sons</u>						ADDRESS <u>Annapolis Md</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

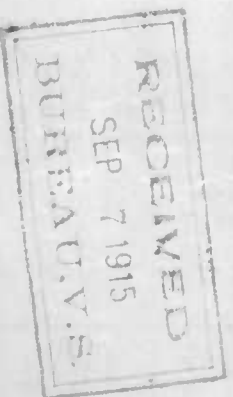
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Senon*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphrenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rewher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

13138

County

a-a-

Village or City

East Port, 389, Eastern Ave.

(No.)

St.

Ward)

Registration Dist. No.

21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Florence Thomas

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Jan - 7, 1915

(Month)

(Day)

(Year)

7 AGE

— yrs. 7 mos. 6 ds.

If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Annapolis Md

10 NAME OF FATHER

James Thomas

11 BIRTHPLACE OF FATHER

a-a-Ce. Md

12 MAIDEN NAME OF MOTHER

Bertha Turner

13 BIRTHPLACE OF MOTHER

Annapolis Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Thomas

(Address)

389 Eastern Ave

15

Filed

Aug 14, 1915

JMS Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 13th 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

August 13, 1915, to August 13th, 1915,

that I last saw him alive on August 13, 1915,

and that death occurred on the date stated above, at 12:00 p.m.

The CAUSE OF DEATH * was as follows:

Gastro Enteritis
Several days

Contributory

Secondary

Gradual (Duration) yrs. mos. ds.

(Signed) John W. Bidout, M. D.

August 11, 1915 (Address) Annapolis

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

John Wesley Cemt.

8-15-1915

20 UNDERTAKER

ADDRESS

E H B Parker & Son

92 West St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

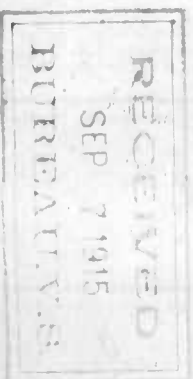
[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

A. A. Co. 13139

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 21

Village or City

Annapolis (No. 7 College Ave. St.; 1st Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thompson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fem.

4 COLOR OR RACE

White.

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Aug 29, 1915.
(Month) (Day) (Year)

7 AGE

If LESS than 1 day, hrs.

yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Annapolis

PARENTS

10 NAME OF FATHER

Chas. Thompson

11 BIRTHPLACE OF FATHER (State or country)

Annapolis

12 MAIDEN NAME OF MOTHER

Mary Canford

13 BIRTHPLACE OF MOTHER (State or country)

A. A. Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Thompson

(Address)

7 College Ave

15

Filed

Aug 29, 1915 Mrs. Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 29, 1915.
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 29, 1915 to Aug 29, 1915.
that I last saw him alive on Aug 29, 1915

and that death occurred on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Stillborn.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. P. Lindleberger, M. D.
Surgeon, U.S.N.
, 191 (Address) U.S. Naval Academy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Grove Cem Aug 29, 1915

20 UNDERTAKER

ADDRESS

Woolley & Son 12 Murray Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

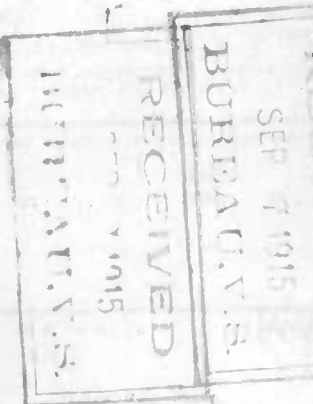
[Approved by L. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

13141

169

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Village or City

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTH PLACE

(State or country)

10 NAME OF FATHER

11 BIRTH PLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTH PLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

File

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory Secondary

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 PLACE OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDEERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

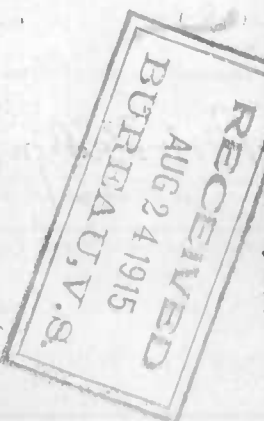
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Foreman*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Pneumonia* ("Pneumonia"); *unqualified*, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misadventure as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 13142
 County Anne Arundel
 Village or City Walesbury (No. 169) St; Ward
 Registered No. 21
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Frederick William Wilson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH — — 1886
 (Month) (Day) (Year)

7 AGE 29 yrs. — mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Farm Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Daniel Wilson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Harrison

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) James Wilson
 (Address) Walesbury

15 Filed 8/29, 1915
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 29, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from —, 191—, to —, 191—,

that I last saw h. — alive on —, 191—

and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) John Wesley Cemetery

(Signed) John Wesley Cemetery Acting as Coroner for State of Maryland
—, 191— (Address) —

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL John Wesley Cemetery DATE OF BURIAL 8/31, 1915

20 UNDERTAKER as county ADDRESS Walesbury
P. J. Williams, Son

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

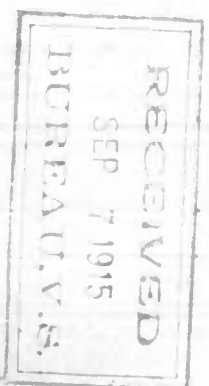
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Anne Arundel</u> 13140		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Davidsonville</u> (No. <u>150</u>)		Registration Dist. No. <u>20</u>	
2 FULL NAME <u>William Thomas Wittington</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Negro</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>August 17th</u> , 191 <u>5</u> (Month) (Day) (Year)			
7 AGE _____ yrs. _____ mos. <u>1</u> ds.		If LESS than 1 day, _____ hrs. _____ OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Baker</u>			
9 BIRTHPLACE (State or country) <u>D. C. Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Percy Wittington</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Dora L. Gray</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Percy Wittington</u> (Address) <u>Harwood, Md.</u>			
15 Filed _____, 191 <u>5</u>			
REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>August 18th</u> , 191 <u>5</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>August 17th</u> , 191 <u>5</u> , to <u>August 18th</u> , 191 <u>5</u> , that I last saw him alive on <u>August 17th</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>10 P. m.</u>			
The CAUSE OF DEATH* was as follows: <u>Protracted 2nd stage of labor colored midwife's case at first child resuscitated only after an hour's work. Evidence of cardiac malformation.</u>			
(Duration) _____ yrs. _____ mos. _____ ds.			
Contributory _____ Secondary _____			
(Duration) _____ yrs. _____ mos. _____ ds.			
(Signed) <u>J. Mortimer Hayes</u> , M. D. <u>Aug. 18th</u> , 191 <u>5</u> . (Address) <u>Davidsonville Md.</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
Where was disease contracted, If not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Ches Chapel Adco. Md.</u>		DATE OF BURIAL <u>Aug. 21st</u> , 191 <u>5</u>	
20 UNDERTAKER <u>Morris Jacob</u>		ADDRESS <u>Owensville, Md.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

SNVICSIAH D YLTLCX EX

RECORD

AMERICAN ASSOCIATION

WRITE PLAINLY WITH UNFADING INK IN THIS SPACE

USE

T O N S A

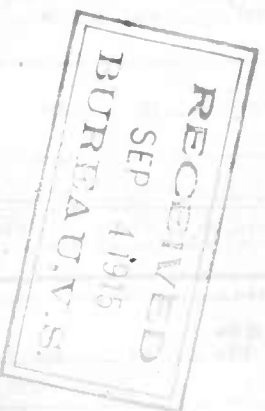
Statement of occupation

tion is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

valcular heart disease; *chronic inflammation*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

13143

County

Anne Arundel

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

24

Village or City

(No.)

A. R. S.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles P. Gummerman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

May 9, 1886
(Month) (Day) (Year)

7 AGE

29 yrs. 1 mos. 3 ds. If LESS than
1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Salesman

(b) General nature of industry business, or establishment in which employed (or employer)

Kean, Ingen & Co. N. Y.

9 BIRTHPLACE

(State or country)

Baltimore Ind

PARENTS

10 NAME OF FATHER

Robert Gummerman

11 BIRTHPLACE OF FATHER

Ind

12 MAIDEN NAME OF MOTHER

Mary Janosky

13 BIRTHPLACE OF MOTHER

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward J. Freund

(Address)

1406 N. Fulton Ave.

15

Filed

Aug 13, 1915 J. B. Keortx M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 12, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

1915, to 1915,

that I last saw him alive on 1915,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Accidental
DrowningContributory
Secondary

(Signed)

James J. Dowling
Aug 13, 1915 (Address) Brooklyn

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Louden Park

8/15, 1915

20 UNDERTAKER

ADDRESS

Jone & W. Lean

833 Linden

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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